EXHIBIT 8 (part 2)

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

American Academy of Pediatric Dentistry	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [5,6]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [8]	•	•	•	•	•
Injury prevention counseling [9]	•	•	•	•	•
Counseling for nonnutritive habits [10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [11]			•	•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially, play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 At first, discuss the need for additional sucking; digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

American Academy of Pediatric Dentistry (AAPD) 2009 "Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/ Counseling"

FOOTNOTES

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9. Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouth guards.
10. At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

909. Other Related Medicaid Programs (This is not an inclusive list)

Rev. 07/08
Rev. 10/10
Rev. 04/14
Rev. 10/14
Rev. 01/15
Rev. 07/17

See the policies and procedures manual of the related programs for complete information. Provider Manuals relevant to EPSDT providers include, but may not be limited to:

- Advanced Nurse Practitioner Services
- Children's Intervention Services (CIS)
- Children's Intervention School Services (CISS)
- Dental Services
- Diagnostic Screening and Preventive Services (DSPS)
- Durable Medical Equipment (DME) Services
- Federally Qualified Health Center (FQHC) Services
- Georgia Pediatric Program (GAPP)
- Hospice Services
- Hospital Services
- Medicaid Medicaid/PeachCare for Kids® Provider Billing Manuals
- Nurse Midwifery Services
- Orthotic and Prosthetic Services
- Pharmacy Services
- Physician Assistant Services
- Physician Services
- Rural Health Clinic (RHC) Services
- Vision Care Services

Provider Manuals are available for downloading. Contact DXC Technology (DXC) at 1-800-766-4456 or visit the website at **www.mmis.georgia.gov** for more information.

910. Summary of Non-covered Services

Rev. 10/11

Non-Covered Services include:

Screenings performed outside the provider's office or clinic.
Services provided in a manner inconsistent with the provisions of this manual.

911. EPSDT Profile (Appointment Tracking System)

Rev. 10/10
Rev. 01/11
Rev. 10/14
Rev. 07/17

The purpose of the EPSDT Appointment Tracking System is to track enrolled Fee-For-Service children eligible for services and to assist providers in conducting and documenting outreach and follow-up activities to EPSDT families and children.

The EPSDT Appointment Tracking System fully supports the State's goals of providing appropriate and continuing screening and treatment services to Georgia's children and of preventing more costly health problems by encouraging regular health care.

This system provides immediate access to medical and dental information on EPSDT members through online inquiry and provides a reminder call system at no cost to the EPSDT provider. These capabilities enhance the control and operation of the EPSDT program and allow information gathering to support research and program development.

In collaboration with the monthly EPSDT roster (Periodic Screenings Due Report), the EPSDT Profile (Appointment Tracking System) provides:

1. Member's demographic information in addition to the last dates for Hearing (Interperiodic Hearing), Vision (Interperiodic Vision), EPSDT Medical and Dental screenings.
2. Detailed information on the member's entire EPSDT history. This allows the provider to view the member's entire EPSDT history and document outreach attempts as a result of letters/rosters distributed. Based on the notice type distributed by DXC, all the provider has to do is document the member's response and a response date. For example, if the provider arranges a future appointment with the member, he/she will select scheduled appointment under the drop down box for response type and enter the date of the appointment under response date.
3. The Response Type options on the drop down box are:
    a. Set Appointment (EPSDT preventive health screening visit)
    b. Set Appointment (Dental)
    c. Set Appointment (Blood Lead).
    d. Screen Completed
4. The last section of the EPSDT Profile is the critical health information. EPSDT medical and dental providers are encouraged to enter information determined to be useful to another Health Care professional in the delivery of care to the member (For example, allergic to Penicillin).
5. If you need further instructions, feel free to click on the help link.

912. EPSDT HIPAA Referral Codes

Rev. 10/14
Rev. 04/15
Rev. 07/15

The Centers for Medicare and Medicaid Services (CMS) defines an EPSDT referral as a member scheduled for another appointment with the EPSDT Provider or a referral to another provider for further needed diagnostic and treatment services as a result of at least one health problem identified during the EPSDT preventive health visit. Effective with HIPAA implementation, CMS and DCH require documentation of EPSDT Referral Codes when submitting EPSDT Screening Code Claims (See Appendix K for examples). When completing the Health Insurance Claim Form [*CMS-1500*], the EPSDT Referral Codes must be entered in the shaded area of box 24H. (See Appendix L)

Example 1: If the EPSDT screening is normal, the referral code is NU (No follow up visit needed)

Example 2: If the EPSDT screening indicates the need for further diagnostic and treatment services and a follow-up visit is necessary, use the applicable referral code(s):

- AV Available, Not Used: Patient refused referral
- S2 Under Treatment: Patient is currently under treatment for health problem and has a return appointment.
- ST New Services Requested: Referral to another provider for diagnostic or corrective treatment/scheduled.

913. Access to Mental Health Services

Rev. 10/14

Behavioral Health Link operates the Georgia Crisis and Access Line (GCAL) through a contract with the Department of of Behavioral Health and Developmental Disabilities (DBHDD). To access mental health, addictive disease, and crisis services 24 hours a day, 7 days per week call 1-800-715-4225 (GCAL) or go to www.mygcal.com

914. Services for Foster Care Children

Rev. 07/11
Rev. 07/12
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 10/15

As of March 3, 2014, children, youth, and young adults in state custody, children receiving adoption assistance and a select group of children under the Juvenile Justice system, were transitioned to Medicaid managed care under the Georgia Families 360° Program. Amerigroup Community Care is the single Care Management Organization (CMO) managing this population (see Appendix I). Children in state custody under the Kenny A. Consent Decree are required to have an EPSDT preventive health visit and a dental visit within 10 days of official transition to state custody. Unless otherwise noted, EPSDT services for all other children enrolled in the Georgia Families 360° Program should follow the Bright Futures Periodicity Schedule.

PART II - CHAPTER 1000

Basis for Reimbursement

1001. Fee for Service Reimbursement Methodology

Rev. 10/10
Rev. 07/14

The Division will pay the lower of the lowest price regularly and routinely offered to any segment of the general public for the same service or items on the same date(s) of service, the lowest price charged to other third party payers, or effective with dates of service July 1, 2003, the statewide maximum allowable reimbursement which is 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the statewide maximum allowable reimbursement – 84.645% of the Region IV Medicare RBRVS in effect at the time the procedure code was adopted.

1002. Vaccines for Children

Since the Vaccines For Children (VFC) program supplies vaccines to providers at no cost to the provider for children birth through eighteen (18) years who have Medicaid, the Division will reimburse an administration fee only for immunizations given to Medicaid enrolled children of this age group. These fees cover the cost of administering the immunizations as well as any paper work involved (including an immunization or health certificate). Refer to Appendix C-2 for the reimbursement rates for the administration of vaccines provided by the VFC program for the Medicaid-eligible children birth through eighteen (18) years. Appendix C-2 also includes the reimbursement rate for the administration of state-purchased vaccines for the PeachCare for Kids® Fee for Service population, for children birth through age eighteen (18) years.

Rev. 10/10
Rev. 07/11
Rev. 10/11
Rev. 03/13
Rev. 04/13
Rev. 07/13
Rev. 10/14

For members nineteen (19) years of age through twenty (20) years of age, VFC stock is not available. Providers must use their own stock of vaccines for these Medicaid eligible members. Health Check providers may include a vaccine administration code on their EPSDT claims when vaccines are administered to members nineteen (19) years of age through twenty (20) years of age. The Division will reimburse for the vaccine product and for vaccine administration. Billing tips for vaccine administration and the effective date for this change are located in Appendix C-1 of this manual and providers are strongly encouraged to follow those tips.

1003. Billing Tips

The following are tips to assist with billing for EPSDT screening services and interperiodic visits.

Rev. 01/10
Rev. 10/10
Rev. 07/13
Rev. 10/14
Rev. 10/15
Rev. 01/16
Rev. 07/17
Rev. 07/18

1. The EPSDT preventive health visit is reimbursed as a package of services. All of the age appropriate EPSDT preventive health visit components (as identified in the updated 2017 Bright Futures periodicity schedule) must be completed for each screening visit and billed under one procedure code except where indicated. All preventive or well-child services, except normal newborn care in the hospital, must be billed under the EPSDT Program following the policies and procedures as outlined in this manual.

2. EPSDT preventive health visits must be referred by or performed by the child's primary care practitioner in order for those services to be reimbursed. Only one (1) periodic preventive or well-child visit will be reimbursed per member at each age appropriate interval, as specified in the periodicity schedule (excluding foster care members).

3. Providers must perform the age appropriate hearing and vision screening in order to be reimbursed for the complete EPSDT preventive health exam. Providers may not refer the child to another provider for hearing and vision screening which is required at the time of the EPSDT preventive health visit.

Rev. 04/11
Rev. 10/14
Rev. 07/15

4. When a visit is found to be medically necessary between periodic visit sequences, the EPSDT provider may be reimbursed by billing the appropriate interperiodic visit procedure code. An interperiodic visit cannot be billed on the same date of service as a complete EPSDT preventive health visit.

5. The Georgia Medicaid program reimburses for many of the Diagnostic and Treatment services under other Medicaid programs.

6. **Developmental Screenings**

Rev. 04/12
Rev. 07/12
Rev. 07/13
Rev. 04/14
Rev. 07/14
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 10/17
Rev. 04/19

A developmental screening should be performed at the following periodic visits: 9, 18, and 30 months. Providers must bill code 96110 with the EP modifier and the appropriate preventive ICD-10 diagnosis code in order to receive reimbursement for this screening.

Only one (1) developmental screening will be reimbursed at each of these intervals. If the child is not seen at the 9, 18, or 30 month visit, a developmental screening should be performed during the catch-up visit for the missed periodic visit. This catch-up developmental screening should be billed, using the EP and HA modifiers with code 96110 and the appropriate preventive ICD-10 code. The provider can only bill one (1) catch-up developmental screening during any one (1) catch-up interval.

Rev. 04/12
Rev. 07/12
Rev. 07/13
Rev. 04/14
Rev. 07/14
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 10/17
Rev. 04/19

ICD-10 Diagnosis Codes (preventive)
Z00.121 or Z00.129
Z02 – Z02.89

7. **Autism Screenings**

Autism screenings should be performed at the 18 and 24 month periodic visits (or catch-up visits). Providers must bill code 96110 with the EP,UA or EP,UA,HA modifiers and the appropriate ICD-10 diagnosis code in order to receive reimbursement for this screening.

Rev. 07/17
Rev. 10/17
Rev. 10/18
Rev. 04/19

Autism screenings when performed outside of the Bright Futures requirements can also be reported. Providers must bill code 96110 with the EP,UA modifiers and Z13.41 or the applicable ICD-10 diagnosis code to receive reimbursement for the screening.

8. **Brief Emotional/Behavioral Assessments**

Periodic Screening Visits

An annual depression screening should be performed for members ages 12 years through 20 years during the EPSDT periodic screening visit. When completed during the periodic visit, the depression screening can be reported as a brief emotional/behavioral assessment. Providers should bill code 96127 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code in order to receive reimbursement.

Rev. 01/16
Rev. 04/16
Rev. 07/17
Rev. 07/18
Rev. 04/19

Non-Periodic Screening Visits (Sick Visits)

Brief emotional /behavioral assessments, when performed during non-periodic screening visits, can also be reported for the following:

- depression screenings (outside of the BF requirements); AND
- emotional/behavioral assessments conducted for other conditions, such as ADHD, suicidal risk, anxiety, eating disorders, etc.

Brief emotional /behavioral assessments performed during non-periodic visits should be billed with the E/M office visit code (992xx) and reported with procedure code 96127, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99.

Procedure code 96127:

- is reimbursed at the current default rate
- should be listed only once per claim for multiple units
  - units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS

9. Patient-Focused Health Risk Assessments

Rev. 07/18
Rev. 10/18
Rev. 04/19

Patient Focused health risk assessments performed during the EPSDT periodic screening visit in accordance with the Bright Futures requirements may be reported (i.e., tobacco, alcohol, or drug use assessment; anemia risk assessment; lead risk assessment).

Providers should bill procedure code 96160 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code in order to receive reimbursement. Code the health risk assessment (96160) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

Health risk assessments when performed outside of the Bright Futures requirements can also be reported. Health risk assessments performed during non-periodic visits should be reported with procedure code 96160, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99. Code the health risk assessment (96160) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

Procedure Code 96160:

- is reimbursed at the current default rate.
- should be listed only once per claim for multiple units.
- units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS.

10. Caregiver-Focused Health Risk Assessments

Rev. 07/18
Rev. 10/18
Rev. 04/19

Caregiver focused health risk assessments performed during the EPSDT periodic screening visit in accordance with the Bright Futures requirements may be reported, (i.e., maternal depression screening).

A maternal depression screening should be performed during the following EPSDT periodic screening visits:

- By 1 month
- 2 month
- 4 month
- 6 month

Providers should bill procedure code 96161 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code in order to receive reimbursement. Code the caregiver focused health risk assessment (96161) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

Caregiver focused health risk assessments when performed outside of the Bright Futures requirements can also be reported. Health risk assessments performed during non-periodic visits should be reported with procedure code 96161, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99. Code the health risk assessment (96161) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes (90460, 90471-74) for the same visit.

Procedure Code 96161:

- is reimbursed at the current default rate.
- should be listed only once per claim for multiple units.
- units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS.

11. **Hematocrit and Hemoglobin Level**

The laboratory tests due at the twelve (12) month visit for hematocrit and hemoglobin levels may be performed as in office tests at the time of the EPSDT preventive health visit by the PCP; or the blood sample may be obtained by the PCP and submitted to a Medicaid contracted lab; or the member may be sent to a Medicaid contracted lab for the blood draw and laboratory analysis. The PCP must document in the medical record which option was selected. These tests cannot be sent to a non-participating laboratory for analysis.

12. **Federally required Blood Lead Level (BLL) screening**

Rev. 07/09
Rev. 10/09
Rev. 04/11
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 04/15
Rev. 10/15

If FFS EPSDT providers use private laboratories for BLL screening or perform BLL screening using an in office Lead Analyzer, the EPSDT provider cannot file a claim for reimbursement of the BLL test.

The Georgia Public Health Laboratory provides analysis of blood lead specimen and charges a laboratory fee. Fee for Service providers may submit claims to DCH for this fee if the blood sample is obtained by them during the visit and sent to the GPHL for analysis. To ensure accurate reimbursement, FFS providers must submit the CPT code 83655 with modifier EP and 90 or 91 on the CMS 1500 claim form along with the CPT codes 36415 or 36416 – modifier EP and ICD-10 diagnosis code Z13.88. Additional details regarding this process are contained in Appendix C-4.

13. **Vaccine Administration**

Rev. 07/11
Rev. 04/12
Rev. 04/13
Rev. 07/13
Rev. 01/14
Rev. 10/14

In order to receive the administration fee from the Division for administering federally or state purchased vaccines for children 0 – 18 years of age, the child must be a Medicaid or PeachCare for Kids® member. Since the federally or state purchased vaccines are provided at no cost to the provider, the Division will only reimburse an administration fee based upon the Division's maximum allowable rate. (See Chapter 1000, Section 1002). The vaccine's National Drug Code (NDC) is not required to be included on the EPSDT claim for reimbursement for the administration of federally or state purchased vaccines for children 0-18 years of age.

Beginning April 1, 2013, providers should bill any and all of the following appropriate vaccine administration codes, when administering VFC vaccines, as they apply: 90460, 90471, 90472, 90473, 90474. Additional details regarding the use of the vaccine administration codes are contained in Appendix C-1.

Rev. 04/14
Rev. 07/14
Rev. 10/14

EPSDT providers may bill the EPSDT Program for vaccines administered to members nineteen (19) years of age through twenty (20) years of age. Include the vaccine CPT code, diagnosis code, and NDC, along with the appropriate vaccine administration code**(s)** [90471, 90472, 90473, 90474] on the EPSDT claim. The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration. Additional details regarding the use of the vaccine administration codes and the effective date for this change are contained in Appendix C-1.

Rev. 10/07
Rev. 10/10
Rev. 07/11
Rev. 04/14
Rev. 10/14
Rev. 07/15
Rev. 07/17

14. **Office Visit Codes**

Providers must use place of service (POS) code 99 when billing office visits for EPSDT preventive health screening services. All diagnostic x-ray, laboratory testing (except hematocrit, hemoglobin) and/or treatment services provided to the EPSDT member at the time of the preventive health visit, can be billed on the same CMS 1500 claim form as the EPSDT preventive health visit if the EPSDT provider uses a CMS 1500 form to bill Diagnostic and Treatment Services (i.e., Physician Services, Nurse Practitioner Services, etc.).

Effective May 1, 2015, paper claims are no longer accepted by DXC Technology. As part of the Georgia Paperless Initiative, providers are required to submit CMS 1500 claims electronically over the GAMMIS web portal. For more information regarding the Paperless Initiative, please access the web portal and review all related Banner Messages.

If an EPSDT provider uses a UB 04 to bill Diagnostic and Treatment services (i.e., Hospitals, Rural Health Clinics, etc.), they may also bill the EPSDT preventive health visit services on the UB 04.

Rev. 10/11
Rev. 04/12

15. **School-Based Influenza Vaccine Clinics**

Public Health providers must use place of service (POS) code 03 when billing the vaccine administration fee for Influenza vaccines administered during school-based Influenza vaccine clinics held within their county of jurisdiction. Only the Influenza vaccine administration will be reimbursed during these school-based Influenza vaccine clinics.

Rev. 04/14
Rev. 10/14
Rev. 04/16

16. **School-Based Telemedicine Services**

LEAs enrolled as Health Check providers to serve as telemedicine originating sites only will be allowed to bill the telemedicine originating site facility fee (procedure code Q3014). The LEA provider should report procedure code Q3014 along with the EP and GT modifiers, POS 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider's claim.

The rendering provider serving as the telemedicine distant site should report the E/M office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s).

In order for the originating site (LEA) provider to receive reimbursement for procedure code Q3014, a corresponding paid history claim from the distant site provider must be found in GAMMIS. The distant site provider's claim billed for the same member, same date of service, with an E/M office visit code (992xx), the same ICD-10 diagnosis code(s) and the GT modifier, will confirm that a telemedicine service was rendered. If no record of the E/M claim is found that aligns with the LEA provider's originating site claim, the originating site claim will suspend up to 30 days after submission in search of the E/M claim. If no record of an E/M claim is found within 30 days after submission of the LEA provider's originating site claim, reimbursement to the LEA provider will be denied. It is the responsibility of the LEA provider to contact the provider who rendered the distant site service to determine if the E/M visit was billed.

The telemedicine originating facility fee is reimbursed at the current DEFAULT rate.

17. Consultation Services

Rev. 07/14
Rev. 10/14

Effective July 1, 2014, providers enrolled in the EPSDT Program, may bill for reimbursement of the following office/outpatient consultation codes: 99241, 99242, 99243, 99244, 99245. The EP modifier must be added to the applicable code along any other applicable modifiers. A consultation service can be rendered once every three years.

18. Tobacco Cessation Counseling Services

Rev. 10/14
Rev. 04/15

Effective January 1, 2014, the Division began coverage of tobacco cessation counseling services to all Medicaid members. Providers enrolled in the EPSDT Program may bill 99406 and 99407 for the reimbursement of tobacco cessation counseling. The EP modifier must be added to the applicable code.

The tobacco cessation counseling must be rendered in a face-to-face setting with the member. Only two 12-week tobacco cessation treatment periods will be allowed per member per year. The provider must document the services in the member's medical record every 30 days during the 12-week treatment period.

19. Incontinence Supplies

Rev. 01/16
Rev. 01/20

Incontinence supplies are covered for children ages 2 through 20 years who have an underlying medical condition that prevents control of the bowels or bladder. Incontinence supplies are not covered for convenience. Children under the age of 2 years will be considered for coverge on a case-by-case basis. Since incontinence supplies are not covered for members over 20 years of age, or on a general basis for members under 21 years, providers must ensure the following for services to be considered for coverage:

- the item is considered durable medical equipment (DME);
- there is a current order prescribed by a physician; and

- a prior authorization (PA) must be submitted which includes documentation of medical necessity.

The following procedure codes are covered under DME services with unique HCPCS codes, but are without Medicare-based or nationally accepted rates (T4521-T4535, T4541, T4544). These HCPCS codes require a PA. Refer to the DME Manual for further guidance.

20. **Fluoride Varnish**

Rev. 04/16
Rev. 10/16

Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years.

21. **Other Procedure Codes**

Rev. 04/15

When billing for EPSDT screening services and interperiodic visits, only the procedure codes for those services found in this manual may be reimbursed under the EPSDT Program. Reimbursement for other services billable to Medicaid is covered under the program areas overseeing the delivery of those services.

22. **National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) Limits**

Rev. 04/16

Providers are reminded to bill in compliance with the NCCI MUE limit for procedure codes and to check the MUE file, at minimum, on a quarterly basis for updates. Procedure codes submitted with frequencies greater than the allowed MUE will be denied according to the NCCI MUE regulations set by CMS.

23. **NCCI Procedure-To-Procedure (PTP) Edits**

Rev. 10/18

Providers are reminded to bill in compliance with the NCCI PTP edits. The NCCI PTP edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported. Procedure codes that should not be reported together will be denied according to the NCCI PTP edits defined by CMS.

24. Other Reimbursement Rates

Rev. 04/16
Rev. 10/16
Rev. 07/17
Rev. 07/18

OTHER REIMBURSEMENT RATES		
Procedure Code & Description	**Modifier(s)**	**Current Default Rate**
96110 – Developmental Screening	EP or EP HA	$11.77
96110 – Autism Screening	EP UA or EP UA HA	$11.77
96127 – Brief Emotional/ Behavioral Assessment (depression screening)	EP	$4.55
96160 – Patient-Focused Health Risk Assessment (i.e., tobacco, alcohol, drug use risk assessment)	EP	$3.95
96161 – Caregiver-Focused Health Risk Assessment (i.e., maternal depression screening)	EP	$3.95
Q3014 – Telehealth Originating Site Facility Fee	EP	$20.52
99241 – Patient Office Consultation, typically 15 minutes	EP	$48.05
99242 – Patient Office Consultation, typically 30 minutes	EP	$78.78
99243 – Patient Office Consultation, typically 40 minutes	EP	$100.50
99244 – Patient Office Consultation, typically 60 minutes	EP	$139.12
99245 – Patient Office Consultation, typically 80 minutes	EP	$180.61
99406 – Smoking and Tobacco Use Intermediate Counseling, Greater than 3 minutes up to 10 minutes	EP	$10.51
99407 – Smoking and Tobacco Use Intensive Counseling, Greater than 10 minutes	EP	$20.71

Reviewed 3/11/2020

Rev. 10/16

Effective July 1, 2016, physicians and physician extenders who are eligible for the HB 751 FY 2017 Primary Care Providers (PCP) rate increase will be reimbursed $180.26 when procedure code 99244 is billed for established Medicaid-eligible and PeachCare for Kids®-eligible members.

Rev. 04/18

Effective July 1, 2017, physicians and physician extenders who are eligible for the HB 44 FY 2018 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated in the table below when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Primary Care Providers (PCP) Rate Increases

Procedure Code	Description	Modifier(s)	HB 751 FY2017 Increased Reimbursement Rate	HB 44 FY2018 Increased Reimbursement Rate
99241	Patient Office Consultation, typically 15 minutes	EP	n/a	$48.05
99242	Patient Office Consultation, typically 30 minutes	EP	n/a	$88.77
99243	Patient Office Consultation, typically 40 minutes	EP	n/a	$121.39
99244	Patient Office Consultation, typically 60 minutes	EP	$180.26	n/a
99245	Patient Office Consultation, typically 80 minutes	EP	n/a	$220.80
99406	– Smoking and Tobacco Use Intermediate Counseling, greater than 3 min up to 10 min	EP	n/a	$13.59
99407	– Smoking and Tobacco Use Intensive Counseling, greater than 10 minutes	EP	n/a	$26.91

Questions regarding Medicaid billing should be directed to Georgia Health Partnership (GHP) at 1-800-766-4456 or 'contact us' at www.mmis.georgia.gov

APPENDIX A

Guidelines in Screening and Reporting Elevated Blood Lead Levels

Rev. 04/12
Rev. 04/14

The mission of the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) is to eliminate childhood lead poisoning in Georgia.

Screening Guidelines: Children

Rev. 04/12
Rev. 07/15
Rev. 07/16
Rev. 01/20

Screening for lead poisoning helps identify children who need interventions to reduce their blood lead levels. Many children who may have been exposed to lead or who are at risk for lead poisoning go without being screened. This makes their chances of being harmed by lead greater. Parents and providers should know when a child should be tested for lead poisoning.

Guidelines in Screening and Reporting Elevated Blood Lead Levels:

Lead Screening Requirements & Medical Management Recommendations

(For Children ages 6 to 72 months)

GHHLPPP
RISK FACTORS ASSESSMENT QUESTIONNAIRE

---ask these questions at the 6, 9, and 18 months and 3, 4, 5, 6 years of age preventive visits---

Rev. 04/20

1. Does your child live in or often visit a house that may have been built before 1978?
2. Does your child live in or often visit a house, built before 1978, that is being remodeled or is having paint removed?
3. Does your child live with or often visit another child that had or has an elevated blood lead level?
4. Does your child live with anyone who works at a job where lead may be found or has a hobby that uses lead?
5. Does your child chew on or eat non-food items like paint chips or dirt?
6. Does your child live near an active lead smelter, battery recycle plant, or other industry likely to release lead?
7. Does your child receive medicines such as greta, azarcon, kohl, or pay-loo-ah?

When using the questionnaire, blood lead tesst should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

https://dph.georgia.gov/environmental-health/healthy-homes-and-lead-poisoning-prevention

Test the blood of ALL Medicaid children for lead poisoning at 12 and 24 months of age AND children 3 to 6 years of age if never tested *regardless* of their risk factors.

Rev. 10/12
Rev. 04/14
Rev. 07/15
Rev. 10/19

Lead Screening Requirements and Medical Management Recommendations for Children

Test ALL Medicaid children at 12 and 24 months of age AND children 3 to 6 years of age if never tested *regardless of their risk factors*

IT IS A FEDERAL REQUIREMENT

Recommended Medical and Case Management Actions

Blood Lead Level (BLL)	Confirmatory Blood Lead Test	Hospitalization	Chelation Therapy (A)	Blood Lead Level Re-Test	Referrals (B)	History & Physical (C)	Lead Poisoning Education (D)	Reducing Exposure & Absorption (E)
5 - 9 µg/dL	No	No	No	Within 1 year	No	No	Yes	Yes
10 - 14 µg/dL	Within 1 day to 3 months – venous or capillary	No	No	See Retest Chart below	Yes	Yes	Yes	Yes
15 - 19 µg/dL	Within 1 day to 3 months – venous or capillary	No	No	See Retest Chart below	Yes	Yes	Yes	Yes
20 - 44 µg/dL	Within 1 day to 3 months – venous or capillary	No	No	See Retest Chart below	Yes	Yes	Yes	Yes
45 - 69 µg/dL	Within 1 day to 1 month – venous or capillary	No if home is lead-safe	Yes	See Retest Chart below	Yes	Yes	Yes	Yes
70 µg/dL or >	within 24-48 hours, venous only	YES MEDICAL EMERGENCY	Yes	See Retest Chart below	Yes	Yes	Yes	Yes
THERE IS NO SAFE LEVEL OF LEAD IN THE BODY. DAMAGE CAUSED BY LEAD POISONING IS PERMANENT AND IRREVERSIBLE!								

[1] *If the child's blood lead level persists between 10-14 ug/dL (2 blood lead tests 3 months apart) proceed according to the level of care for 15-19 µg/dL.*

Explanation of Recommended Medical and Case Management Actions

(A) Chelation Therapy: if chelation therapy is indicated, the child should be immediately removed from the hazardous environment until the child's environment is made lead-safe; however, if the home is already lead-safe, the child may remain in the home unless hospitalization is indicated.

(B) Referrals: contact local health department and/or **GHHLPPP** to assist in case management and environmental investigations.

Rev. 10/12
Rev. 04/14
Rev. 07/15
Rev. 10/19

(C) History and Physical: take medical, environmental, and nutritional history, test for anemia and iron deficiency, assess neurological, psychosocial, and language development, screen all siblings under age 6, and evaluate risk of other family members, especially pregnant women.

(D) Lead Poisoning Education: discuss sources of lead, effects of lead, lead-based paint hazards associated with living in a pre-1978 and/or renovating a pre-1978 home. Discuss how lead affects prenatal care and well child care at ages 3, 6, and 12 months and explain what blood lead levels mean and their significance. Lastly, contact **GHHLPPP** for information.

(E) Reducing Exposure and Absorption: discuss damp cleaning to remove lead dust on surfaces, eliminating access to deteriorating lead paint surfaces, and ensuring regular meals which are low in fat and rich in calcium and iron; contact **GHHLPPP** for materials.

ELEVATED BLOOD LEAD RE-TEST CHART

Use this chart to determine when to retest children who are *confirmed as lead-poisoned.* Venous testing is **strongly preferred**, but capillary testing is acceptable.

If the child's last confirmed BLL was...	and... if the child's blood lead level HAS NOT DROPPED at least 3 µg/dl over a span of at least 3 months... then test the child again in...	and... if the child's blood lead level HAS DROPPED at least 3 µg/dl over a span of at least 3 months... then test the child again in...
10-14 µg/dL	3 months	6 months
15-19 µg/dL	3 months	3 months
20-24 µg/dL	1 month	2 months
25-44 µg/dL	1 month	1 month
45-69 µg/dL	1 month after chelation	1 month after chelation
≥70 µg/dL	1 month after chelation	1 month after chelation

Retesting should occur until the blood lead level is less than 10 µg/dL for six months, all lead hazards have been removed, housing is made lead-safe, and no new exposure exists.

Department of Public Health, 2 Peachtree Street NW, 13th Floor, Atlanta, Ga, 30303,
Phone (404) 657-6534 | For more info: Toll Free 1-888-247-9054 | Fax (404) 463-4039
https://dph.georgia.gov/healthy-homes-and-lead-poisoning-prevention
https://dph.georgia.gov/lead-screening-case-management-lab-submissions-reporting-guidelines

Lead Screening Guidelines for Children
Screening for lead poisoning helps identify children who need interventions to reduce their blood lead levels. Many children who may have been exposed to lead or who are at risk for lead poisoning go without being screened. This makes their chances of being harmed by lead greater. Parents and providers should know when a child should be tested for lead poisoning.

Medicaid and PeachCare for Kids
All children enrolled in Medicaid and PeachCare for Kids® should be tested for lead poisoning and offered certain services based on the following schedule:

Age	Lead Blood Test	Lead Risk Assessment Questionnaire	Anticipatory Guidance
6 months		X	X
9 months		X	X
12 months	X (risk assessment if not enrolled in Medicaid)		X
24 months	X (risk assessment if not enrolled in Medicaid)		X
36-72 months	X - If there's no record of previous test at 12 and 24 months	X - Complete annually unless blood lead test performed	X

Source: https://dph.georgia.gov/lead-screening-guidelines-children

Lead Risk Assessment Questionnaire

Rev. 04/14
Rev. 10/14

The GHHLPPP Childhood Lead Risk Questionnaire can be found at: https://dph.georgia.gov/lead-screening-guidelines-children in English, Spanish and Vietnamese.

Rev. 04/12

When using the questionnaire, blood lead tests should be done right away if the child is at high risk (one or more "yes" or "I don't know" answers on the lead risk assessment questionnaire) for lead exposure. Completing this questionnaire does not count as a lead screening.

Blood Lead Test

Rev. 04/12
Rev. 07/15
Rev. 10/19

A blood test is the preferred method for lead screening. There are two tests used to obtain blood lead specimens: capillary blood test or venous blood test. Finger stick capillary blood tests (the Lead Care II Analyzer uses capillary blood) can be done as the initial screening. However, a lab analyzed sample is necessary for confirmation. Safety measures should be taken to reduce the risk of contamination of the capillary blood sample. These measures include:

- Rinsing powder from the examination gloves
- Thoroughly washing patient's hands with soap and water, then drying them before taking a sample.

A venous blood test can be done as the initial screening as well. This method should always be used to confirm elevated blood lead test results when a capillary test was used as the initial screening. Alternatively, a second lab analyzed capillary test can be used to confirm an initial capillary test when the test is conducted according to the schedule in Table 1 - Lead Screening Requirements and Medical Management Recommendations for Children ages 6 to 72 months.

Rev. 04/12
Rev. 07/15
Rev. 07/17

All venous sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory.

If a child's capillary Blood Lead Test comes back elevated (≥ 10ug/dL reported by a certified lab or ≥ 6ug/dL using the Lead Care II analyzer), then a confirmatory test must be performed. The confirmatory diagnostic test should be lab analyzed and done according to the schedule in Table 1 - Lead Screening Requirements and Medical Management Recommendations for Children ages 6 to 72 months.

If the schedule in Table 1 is not followed and 6 months has gone by since the initial screening test, the next test is considered a new screening test. Decisions on follow-up testing should be made based on the results of the new screening test, not on the basis of the original screening test.

Lab Submission

Rev. 10/19

The Waycross Regional Laboratory provides an analysis of blood lead specimens to Georgia children less than 72 months of age. The provider's office should contact the laboratory to use this service. GHHLPPP does not recommend or endorse the use of another lab.

Waycross Public Health Laboratory
1751 Gus Karle Parkway
Waycross, Georgia 31503
912-338-7050

Reporting Guidelines

Laboratories attempt to test each lead specimen on the day it arrives. The reports are mailed back to providers on the same day. All laboratory data is sent monthly in electronic format to GHHLPPP.

Rev. 10/19

Providers should report the results of all screening and follow-up blood lead level (BLL) tests to GHLPPP. Because data from laboratories often do not include demographic information, complete reports from providers' office are very important. If reports are not complete, GHHLPPP may contact providers' offices for missing information.

Results must be reported by:

- State Electronic Notification Disease Surveillance System (SendSS)
- SendSS is a web-based reporting system designed to collect information about notifiable diseases in Georgia. Click here for reporting instructions. Click here for Blood Lead Test Reporting Log spreadsheet template.

Rev. 04/12
Rev. 04/14
Rev. 10/19

Providers who utilize the Lead Care II Analyzer to perform blood lead tests should report the Lead Care II Analyzer generated results to the GHHLPPP. On a weekly basis, providers should upload their test results to the State Electronic Notification Disease Surveillance System (SendSS). SendSS recommends providers keep track of their Lead Care II Analyzer test results by documenting those results in a Blood Lead Test Reporting Log provided by GHHLPPP (link above). If reports are not complete, GHHLPPP may contact providers' offices for missing information. Complete a new Blood Lead Reporting each week. Upload the Blood Lead Test Reporting Log and submit weekly to the GHHLPPP via SendSS. For uploading instructions, refer to the *SendSS Registration and Login Manual for Uploading Lead Report Files*.

Blood Lead Test Reporting Log: Click here

SendSS
State Electronic Notifiable Disease Surveillance System

Rev. 04/12

Registration and Login Manual for Uploading Lead Report Files

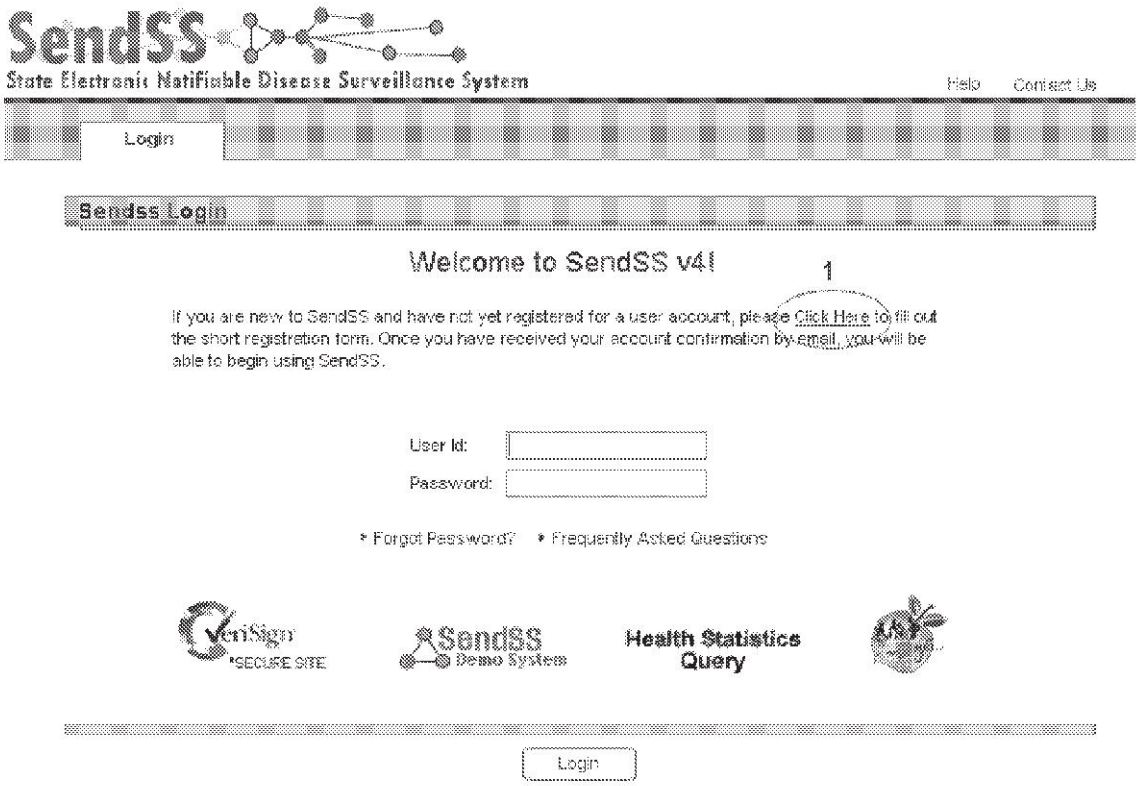
Version 4.0

Table of Contents

Registration and Login Manual for Uploading Lead Report Files may be accessed at:

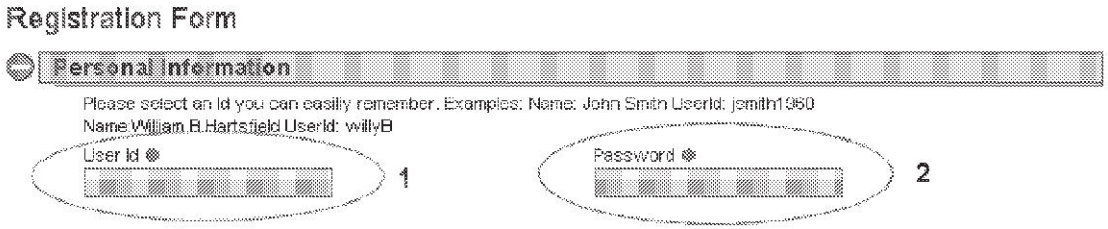
https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/EnvHealthLeadReportingInstructions.pdf

Registration procedure



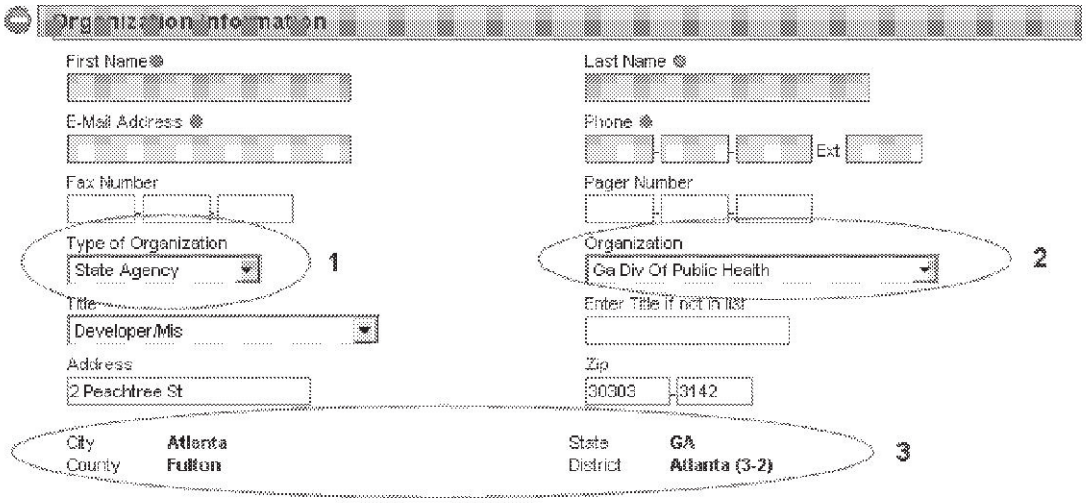
The home page can be accessed with the following URL and is best viewed using Microsoft Internet Explorer Version 6.x.x. https://sendss.state.ga.us

In order to gain access to SENDSS, you will first need to fill in a registration form and create a login. This can be done by pressing "Click Here" as shown above [1].

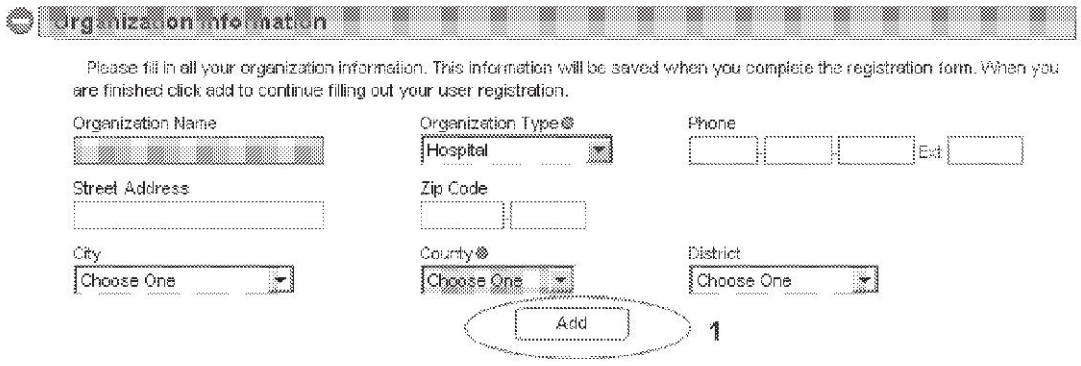


- **Remember to use a userid that is easily remembered**
- **Fill out Password Information**

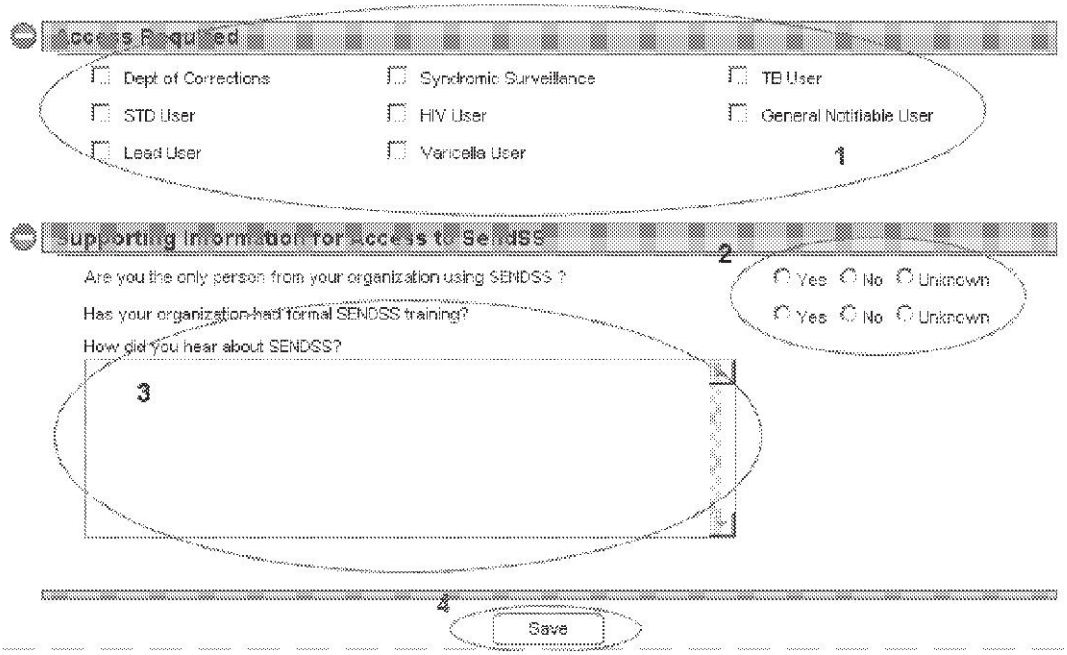
Registration Form (continued)



1. Select the type of organization you will be entering cases for.
2. Select the name of your organization. If you cannot find your organization select "Enter a New Organization" from the select box and the section will change and appear as below.
3. City, County, State, and District are not editable once an organization is entered into SendSS. If all the information for this section does not appear when you select an organization, you will be asked to provide it the first time you log in to SendSS.

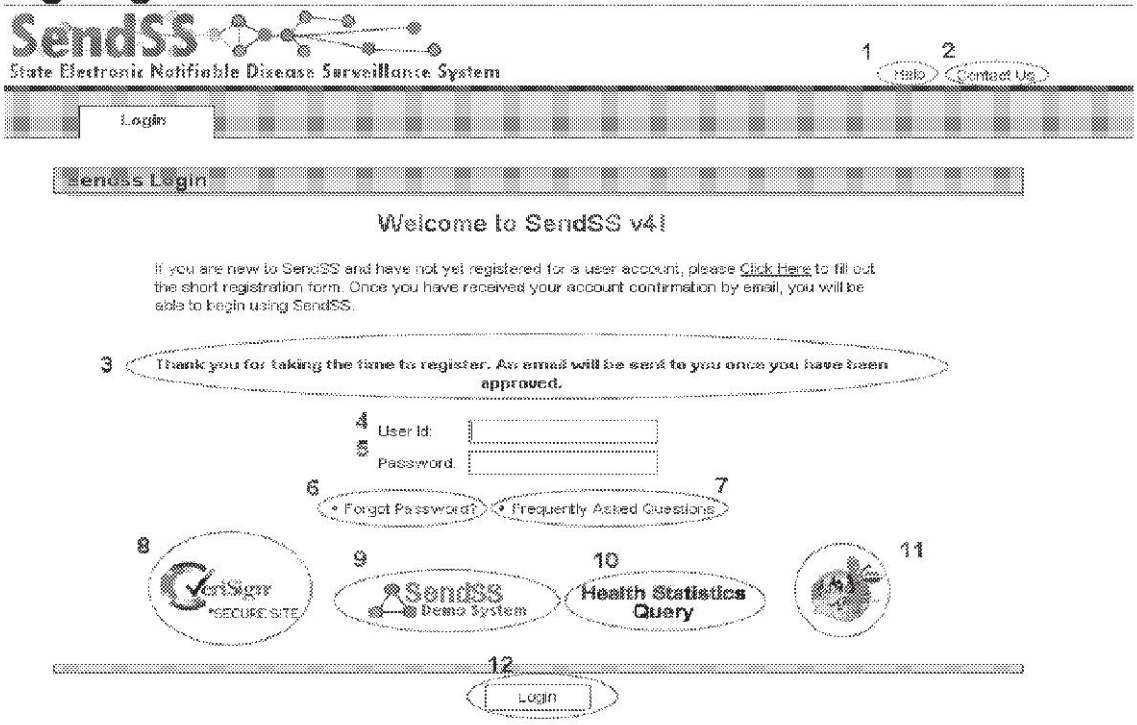


1. This section appears if a new user needs to enter an organization for which SendSS does not have a current user. Please fill in all information and press "Add". Then continue filling out the registration form.



1. Select the type of access you will require from SendSS from section 1. At a minimum, please check "**Lead User**"
2. Please answer the questions in section 2.
3. Enter any comments is this section
4. Press "Save" to complete your registration.

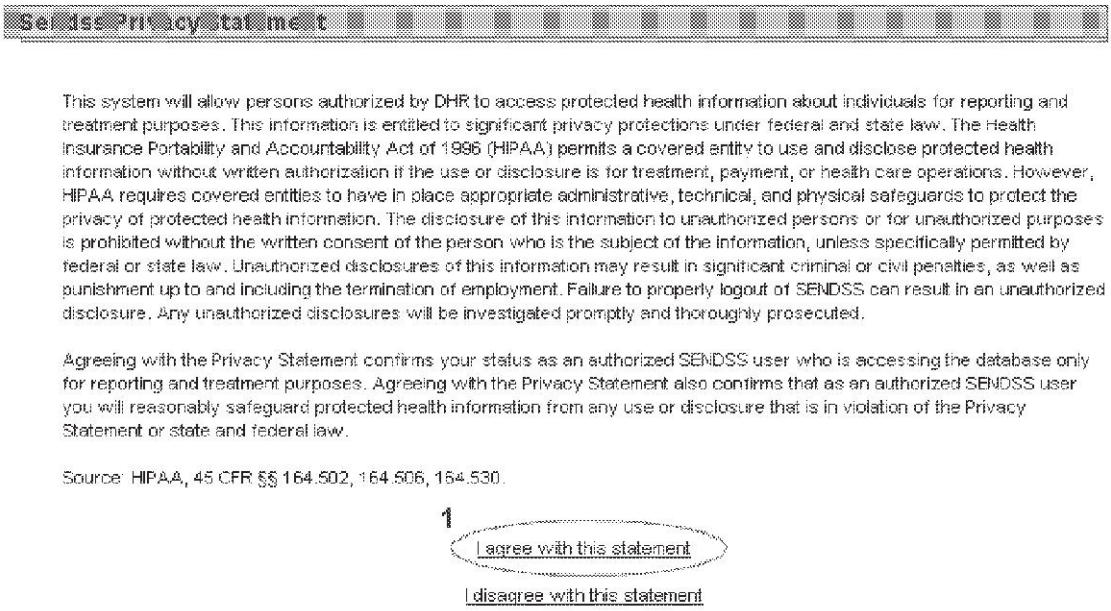
Signing In



Key to features

1. Help – A link to documentation and manual for SendSS version 4.0.
2. Contact Us – Send an internal message.
3. Warnings and Messages – Text will appear in red to alert users of failed logins or other relevant messages such as successful registration.
4. User Id – Enter the user id you chose when registering.
5. Password – Enter the password you chose when registering. This password must be reset every 3 months. After 3 months SendSS will allow 3 grace logins before locking your account. You will be prompted to change your password at this time.
6. Forgot Password – Click here to request your password.
7. Frequently Asked Questions –
8. VeriSign -- The certificate authority utilized by SENDSS is Verisign. Clicking on the graphic will display the validity of the SSL certificate.
9. SendSS Demo System -- Clicking on this image will take you to the Demonstration site. A separate registration is required to access this site.
10. Health Statistics Query -- This link will take you to the Notifiable Disease Query
11. Georgia Peach – Click this image to access the Georgia State Epidemiology Web site.

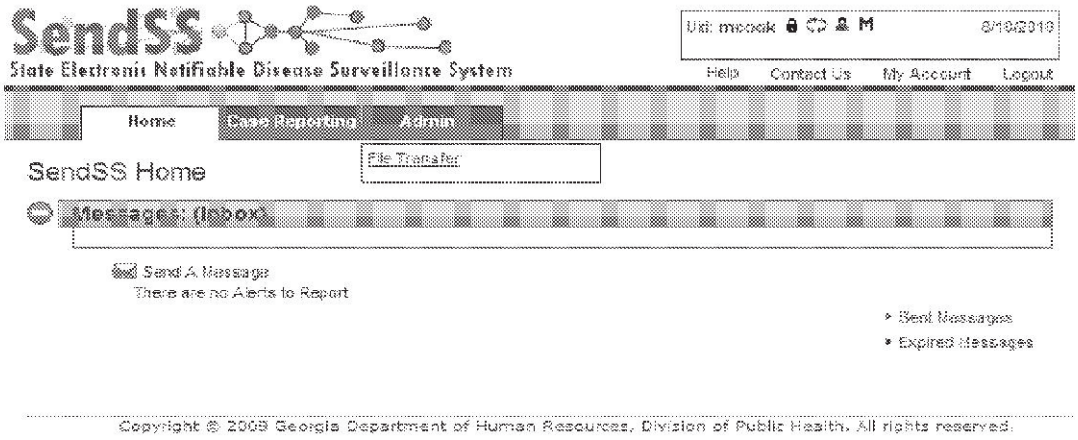
SendSS - Disclaimer



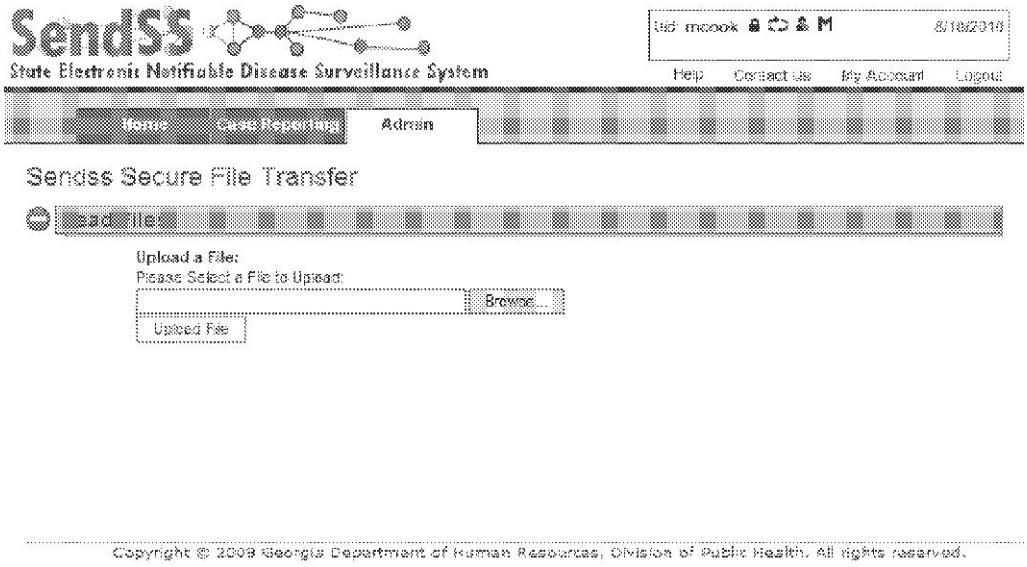
Before you can enter the system, you must accept the Privacy Statement [1]. Selecting "I disagree with this statement" will terminate your login and return you to the login page.

File Upload Process

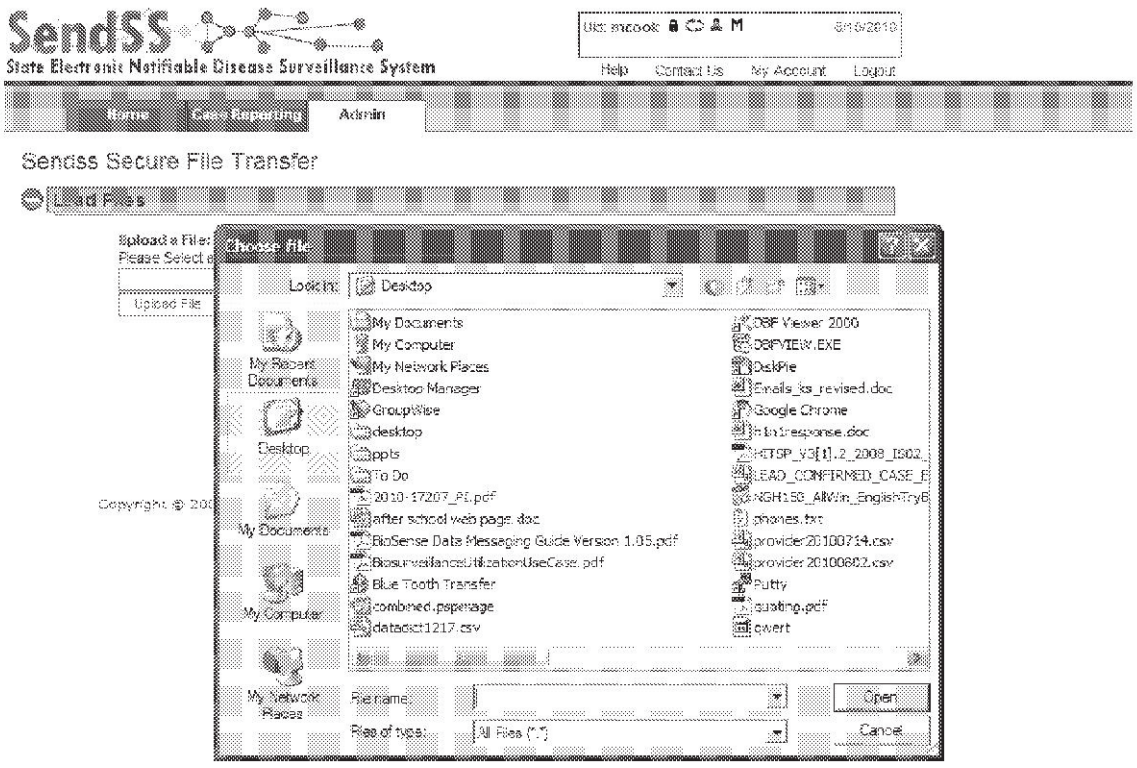
To upload a lead report file, begin by moving your mouse over the "Admin Tab" and clicking on the "File Transfer" menu item:



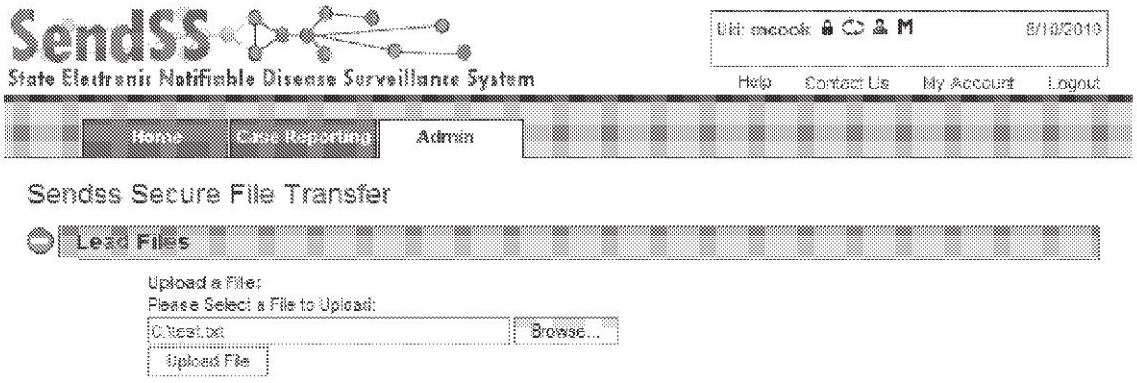
You will see a screen that asks you to select a file for uploading. To do this, click the browse button:



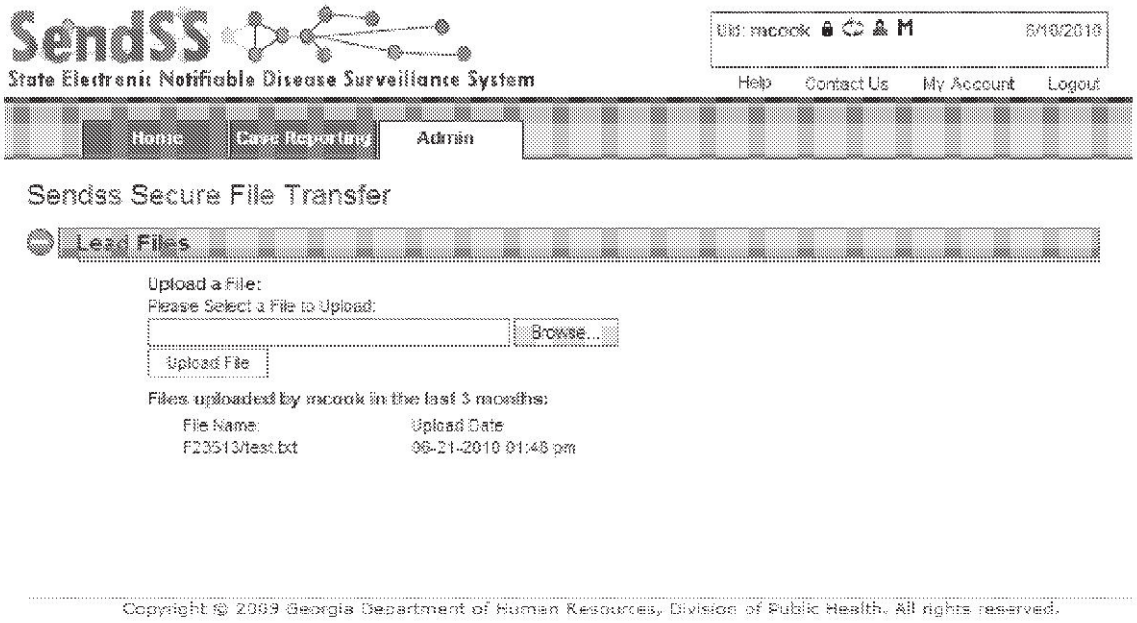
Locate the folder where you have saved the lead report files and then click the file name. After clicking on the file, click the open button:



You should see the file name that you selected appear in the box next to the browse button:



Click the "Upload File" button. Once the file is uploaded the screen will refresh and the file will appear in the list of recently uploaded files, as below:



You are finished!

Rev. 02/12
Rev. 10/19

Georgia Childhood Lead Poisoning Prevention Program
Case Management Guidelines

Blood Lead Level	Recommendations
< 5 µg/dL	• No safe threshold above "0" has been identified. Medical provider should provide anticipatory guidance for any blood lead level (BLL) above "0".
5 – 9µg/dL	• Perform additional blood lead tests within 1 year according to the Georgia Childhood Lead Screening Guidelines.* • GHHLPPP will provide educational material to parents • GHHLPPP will contact parents for consultation on confirmed cases
10 – 19µg/dL	Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 3 months. If child is < 12 months old or it is believed the BLL may be increasing rapidly, the test should be done earlier. • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct nutritional assessment • Continue testing at 3 month intervals until all the following conditions are met: o BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) o Lead hazards have been controlled. o There are no new sources of lead exposure GHHLPPP or the Case Management Provider will send, by mail, or deliver the following information to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 3 months. • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or Case Management Provider will give in-person (or in some cases by phone or mail) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 2 weeks of receiving referral from GHHLPPP.

Rev. 02/12
Rev. 10/19

Georgia Childhood Lead Poisoning Prevention Program
Case Management Guidelines

Blood Lead Level	Recommendations
20 – 44µg/dL	Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 1 week-1 month • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct comprehensive medical evaluation including nutritional assessment • Continue testing at 3 month intervals until all the following conditions are met: o BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) o Lead hazards have been controlled, o There are no new sources of lead exposure GHHLPPP or the Case Management Provider will send, by mail, the following information to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 1 week to 1 month, • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone or mail) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 1-2 weeks of receiving referral from GHHLPPP. • Send by mail (or in some cases call) a summary of risk assessment and recommendations to the caregiver, property owner and medical provider. • Provide a copy of the risk assessment in approved format to GHHLPPP.
45 – 69µg/dL	***URGENT*** Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 24-48 hours. • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct comprehensive medical evaluation, including nutrition assessment and consider pharmacologic treatment. Contact the Georgia Poison Center for consultation.

Rev. 02/12
Rev. 10/19

Georgia Childhood Lead Poisoning Prevention Program
Case Management Guidelines

Blood Lead Level	Recommendations
45 – 69µg/dL	• Continue testing at 1-2 month intervals until all the following conditions are met: o BLL has remained <45µg/dL for at least 4 months (two tests at least 2 months apart) then start follow up blood lead testing at 3 month intervals until BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) o All identified lead hazards have been controlled Note: A child receiving chelation therapy MAY NOT return to the home until all lead hazards have been controlled. o There are no new sources of lead exposure. GHHLPPP or the Case Management Provider will give, by phone, the following recommendation to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 24-48 hours, • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 48 hours of receiving referral from GHHLPPP. • Call-in a summary of risk assessment and recommendations to the caregiver, property owner and medical provider. • Provide a copy of the risk assessment in approved format to GHHLPPP.
≥ 70µg/dL	**MEDICAL EMERGENCY.** **DO NOT DELAY MEDICAL TREATMENT.** Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) as emergency lab test. • Conduct immediate medical evaluation and pharmacologic treatment. Contact the Georgia Poison Center for consultation. • Test other children in the home <72 months of age who have not been tested in the last 6 months.

Rev. 02/12
Rev. 10/19

Rev. 10/12
Rev. 04/14

Georgia Childhood Lead Poisoning Prevention Program
Case Management Guidelines

Blood Lead Level	Recommendations
≥ 70µg/dL	• Continue testing at 1-2 month intervals until all the following conditions are met: o BLL remains <45µg/dL for at least 4 months (two tests at least 2 months apart) then start follow up blood lead testing at 3 month intervals until BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) o All identified lead hazards have been controlled Note: A child receiving chelation therapy MAY NOT return to the home until all lead hazards have been controlled. o There are no new sources of lead exposure. GHHLPPP or the Case Management Provider will give, by phone, the following recommendation to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) immediately. • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 24 hours of receiving referral from GHHLPPP. • Call-in a summary of risk assessment and recommendations to the caregiver, property owner and medical provider • Provide a copy of the risk assessment in approved format to GCLPPP. • If child must go to different housing unit post chelation, RHHC will inspect the new unit for lead hazards and inform medical provider that home is lead safe prior to child's release from hospital.

Access guidelines at:
https://dph.georgia.gov/sites/dph.georgia.gov/files/EnvHealth/Lead/EnvHealthLeadCaseManagementGuidelines2018.pdf

*GA-AAP recommends a follow-up blood test within 3 months if the initial test is 5-9 µg/dL

For questions on the GHHLPPP guidelines, please contact:
Georgia Healthy Homes and Lead Poisoning Prevention Program
2 Peachtree Street, NW | 13th Floor | Atlanta, GA 30303
Phone: 404-657-6534 Fax: 404-463-4039
https://dph.georgia.gov/lead

ENVIRONMENTAL LEAD RISK ASSESSMENTS

Rev. 01/13

Certified Lead Risk Assessors who conduct the initial environmental lead risk assessment should bill Medicaid using code T1028 and the appropriate diagnosis code. For follow up clearance inspections following removal of the lead hazards, the certified lead risk assessor should bill Medicaid using code T1028 with the U-1 modifier. For additional information, please consult the Diagnostic Screening and Preventive Services (DSPS) Manual.

	Procedure Code
Initial lead investigation	T1028
Post hazard abatement	T1028 - (Modifier U-1)

Georgia and other Lead Resources

Rev. 04/14

Lead Information for Professionals and Parents

For information on lead poisoning and prevention, professionals and parents can call GHHLPPP (Georgia Healthy Homes and Lead Poisoning Prevention Program) at 404-657-6534 or the National Lead Information Center at 1-800-424-lead (5323).

Georgia Public Health Laboratory (GPHL)

The Georgia Public Health Laboratory, which has locations in Decatur and Waycross performs blood lead testing on children for the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP). Contact information:

GPHL
1749 Clairmont Road
Decatur, GA 30033
Phone 1-800-GEORGIA.

Emergency Information on Lead:

Call the Georgia Poison Center at 1-800-222-1222.

Sources of Lead

Common Sources of Lead

- Lead-based paint
- Lead dust, which is produced by aging lead-based paint
- Soil, which is contaminated by lead emissions from gasoline (prior to 1978), lead-based paint chips, storage of old batteries, etc.
- Water which flows through lead pipes or copper pipes soldered with lead (prior to 1986)
- Improperly glazed ceramic pottery and cooking utensils

Industries

- Battery manufacturers or reclamation
- Window replacement
- Bronze manufacture
- Firing range instructors
- Gas station attendants
- Glass manufacturers
- Lead pigment manufacture
- Lead smelters and refiners
- Plumbers, pipe fitters
- Policemen who work in automobile tunnels
- Printers
- Radiator manufacture or repair
- Shipbuilders
- Welders or Cutters – Steel burning or cutting (dismantling bridges, ships, etc.)
- Bridge or ship workers (including airports and boats)
- Construction workers, particularly those doing:
  - Department of Transportation (DOT) Sign Makers
  - Painting
  - Remodeling
  - Renovation
  - Road work (specifically painters)

Hobbies, Sports, Other

- Moonshine whiskey
- Car or boat repair
- Fishing
- Glazed pottery making
- Home remodeling
- Lead soldering
- Making lead shot or bullet
- Shooting at firing range
- Stained glass manufacture
- Additives to some "health foods" and imported candies
- Substance Use
- Toy soldiers (leaded)
- Folk Remedies – Most commonly found in Mexican, Asian Indian, and Middle Eastern groups. Names include: *Alarcon, Alkohl, Azarcon, Bali Goli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, Rueda*. Cosmetics, used commonly by those from the Middle East and India.

APPENDIX B

Guidelines in Screening and Reporting for TB Disease and Infection

Tuberculin Skin Testing

Mantoux tuberculin skin testing is the standard method of identifying persons infected with M. tuberculosis. Multiple puncture tests should NOT be used to determine whether a person is infected.

The Mantoux test is performed by giving an intradermal injection of 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) into either the volar or dorsal surface of the forearm. The injection should be made with a disposable tuberculin syringe, just beneath the surface of the skin, with the needle bevel facing upward. This should produce a discrete, pale elevation of the skin (a wheal) 6 mm to 10 mm in diameter.

The reaction to the Mantoux test should be read by a trained health care worker 48 to 72 hours after the injection. If a patient fails to show up for the scheduled reading, a positive reaction may still be measurable up to 1 week after testing.

However, if a patient who fails to return within 72 hours has a negative reaction, tuberculin testing should be repeated.

The area of induration (palpable swelling) around the site of injection is the reaction to tuberculin. The diameter of the indurated area should be measured across the forearm (perpendicular to the long axis). Erythema (redness) should not be measured. All reactions should be recorded in millimeters of induration, even those classified as negative. If no induration is found, "0 mm" should be recorded.

Reporting requirements

In Georgia, all tuberculosis must be reported immediately to the local county health department. Physicians, hospitals, laboratories and other health care providers are required to report any of the following:

- Any child less than 5 years discovered with Latent TB Infection
- Any confirmed case of TB
- Any suspected case of TB
- Any person being treated with two (2) or more anti-tuberculosis drugs
- Any positive culture for Mycobacterium tuberculosis
- Any positive smear for AFB (Acid Fast Bacilli)

How to report

- Report cases electronically through the State Electronic Notifiable Disease Surveillance System (SENDSS)
- Complete a Notifiable Disease Report Form and mail in an envelope marked CONFIDENTIAL, or
- Call your District Health Office
- If your District Health Office cannot be reached, call the Georgia Department of Public Health, TB Section at 404-657-2634.

Rev. 07/11
Rev. 10/14
Rev. 10/15

Childhood TB Risk Assessment Questionnaires

The AAP Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents (3rd edition) recommends asking the following questions:

1) Was your child born in a country at high risk for tuberculosis?

2) Has your child traveled (had contact with resident populations) for longer than 1 week to a country a high risk for tuberculosis?

3) Has a family member or contact had tuberculosis or a positive tuberculin skin test?

Resource: https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

For more information about tuberculosis in Georgia: contact
Georgia Tuberculosis (TB) Section
2 Peachtree St. NW
12th Floor
Atlanta, GA 30303
(Phone) 404-657-2634
(Fax) 404-463-3460
The TB Program has the legal responsibility for all TB clients in Georgia regardless of who provides the direct services. TB services are available to all who fall within the service criteria without regard to the client's ability to pay.

Information also available at https://dph.georgia.gov/tuberculosis-tb-prevention-and-control

APPENDIX C-1

Vaccine Administration Codes

Vaccine Administration Codes		
HIPAA Procedure Code	**HIPAA Modifier**	**Procedure Code Description**
90460	EP	**Pediatric Immunization Administration Code.** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional.
90471	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/ toxoid)
90473	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)
90474	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid)

Vaccine Administration Code for Face-to-Face Counseling

90460 - Vaccine administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional.

Rev. 04/13
Rev. 07/13
Rev. 07/14
Rev. 10/14

90460 is reported when both of the following requirements are met: (1) The patient must be 18 years of age or younger. (2) The physician or other qualified health care professional must perform face-to-face vaccine counseling associated with the administration. *(Any clinical staff can do the actual administration of the vaccine per the physician's or the qualified health care professional's orders.)*
If both of these requirements are not met, report a non-age specific vaccine administration code(s) (90471-90474) instead.

90460 may be reported for more than one (1) unit of vaccine administered during a single office visit.

Note: Local Public Health Departments May use vaccine administration code 90460 only if a physician or other qualified health care professional performs face-to-face vaccine counseling associated with administration of the vaccine

A 'qualified health care professional' is an individual who by education, training, licensure/ regulation, facility credentialing (when applicable), and payer policy is able to perform a professional service within their scope of practice and independently report a professional service. These professionals are distinct from 'clinical staff.' A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, facility, and payer policy to perform or assist in the performance of specified professional services, but who does not individually report any professional services. (CPT 2012)

Non-Age Specific Vaccine Administration Codes

Rev. 01/14

These codes must be used when there is no face-to-face physician counseling associated with vaccine administration. The add-on codes (90472, 90474) may also be used in conjunction with the 90460 code.

Codes 90471 and 90473 are used to code for the first vaccine given during a single office visit. Codes 90472 and 90474 are considered add-on codes *(hence the + symbol next to them)* to 90471 and 90473, respectively. This means that the provider will use 90472 and 90474 in addition to 90471 or 90473 if more than one vaccine is administered during a visit. Providers may use 90460 for the first (i.e., counseled) vaccine and 90472 or 90474 for the second (i.e., non-counseled) vaccine. Note that there can only be one first administration during a given visit.

90471 - Vaccine administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)

Rev. 04/13

Do not report 90471 in conjunction with 90473 or 90460

+90472 - Vaccine administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

May use 90472 in conjunction with 90471 or 90473 or 90460

90473 - Vaccine administration (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)

Do not report 90473 in conjunction with 90471 or 90460

+90474 - Vaccine administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

May use 90474 in conjunction with 90471 or 90473 or 90460

Vaccine Administration Codes for 19 – 20 year olds

Rev. 07/13
Rev. 10/14

EPSDT providers may bill the EPSDT benefit for vaccines administered to members nineteen (19) years of age through twenty (20) years of age. Providers must include the vaccine's CPT, NDC, and diagnosis code, along with the appropriate vaccine administration code(s) [90471, 90472, 90473, 90474] on the EPSDT claim. The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration.

Billing Tips

Rev. 04/13
Rev. 07/13
- Code the vaccine administration with the appropriate vaccine administration code and the EP modifier.

- For the vaccine, code the vaccine product code, the associated diagnosis code and the EP modifier.

- The primary vaccine administration code (90460, 90471, or 90473) must precede the add-on vaccine administration code(s) (90472 or 90474), if applicable.

- The vaccine product code must immediately follow the corresponding vaccine administration code.

Rev. 07/15
- Code the vaccine administration code(s), the vaccine product code(s), and the preventive or interperiodic visit on the same claim when vaccines are administered during a preventive or interperiodic visit. Each vaccine administration code should be listed only once per claim. If multiple vaccine product codes correspond to the same vaccine administration code, the vaccine administration code is listed once with the appropriate number of units indicated.

- 90460 may be reported for more than one (1) unit of vaccine administered during a single office visit.

Rev. 07/14
Rev. 10/15
Rev. 04/18
Rev. 07/19
Rev. 01/20
- May report diagnosis code Z00.121 or Z00.129 or Z23 with each of the vaccine administration codes ONLY when vaccines are administered during EPSDT preventive health visits for members through age 17 years.

- May report diagnosis code Z00.00 or Z00.01 or Z23 with the applicable vaccine administration code ONLY when vaccines are administered during EPSDT preventive health visits for members age 15 years through 20 years.

- Use the appropriate vaccine diagnosis code with the vaccine administration code when the vaccine is administered outside of the EPSDT preventive health visit.

Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 04/15
- Code the EPSDT preventive visit (9938x or 9939x) with the EP and the 25 modifiers when vaccines are administered during the preventive health visit.

- Code the EPSDT interperiodic visits (99201-99203 or 99212-99214) with the EP and the 25 modifiers when vaccines are administered during the interperiodic health visit.

Rev. 04/14
- The National Correct Coding Initiative (NCCI) does not allow reimbursement of the 99211 code when it is billed together with any of the vaccine administration codes regardless of whether the 25 modifier is appended to the 99211 code.

Rev. 10/08
Rev. 01/10
Rev. 07/10
Rev. 01/11
Rev. 07/11
Rev. 10/11
Rev. 07/12
Rev. 01/13
Rev. 03/13
Rev. 10/13
Rev. 01/14
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 01/15
Rev. 10/16

Effective January 1, 2013, the vaccine administration reimbursement rates for administering immunizations under the EPSDT Program were adjusted. The Medicaid maximum allowable reimbursement for vaccine administration is $10.00 for Medicaid Fee for Service Providers and $18.50 for PeachCare for Kids® Fee for Service Providers, as indicated in Table C-1a.

Table C-1a

Vaccine Administration Reimbursement Rates		
HIPAA Procedure Code	**Medicaid Fee For Service (FFS) Reimbursement**	**PeachCare for Kids® (PCK) Fee For Service (FFS) Reimbursement**
90460	$10.00	$18.50
90471	$10.00	$18.50
90472	$10.00	$18.50
90473	$10.00	$18.50
90474	$10.00	$18.50

Effective July 1, 2016, physicians and physician extenders who are eligible for the HB 751 FY 2017 Primary Care Providers (PCP) rate increase will be reimbursed the following rates, as indicated below in Table C-1b, when the specified codes are billed for established Medicaid-eligible and PeachCare for Kids®-eligible members.

Table C-1b

Rev. 10/16

Primary Care Providers Rate HB 751 FY2017 Increased Reimbursement Rates Vaccine Administration		
HIPAA Procedure Code	**Medicaid Fee For Service (FFS) Reimbursement**	**PeachCare for Kids® (PCK) Fee For Service (FFS) Reimbursement**
90460	$21.93	$21.93
90471	$23.54	$23.54
90472	$11.98	$18.50

Rev. 04/18

Effective July 1, 2017, physicians and physician extenders who are eligible for the HB 44 FY 2018 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in Table C-1c, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Table C-1c

Primary Care Providers Rate HB 44 FY2018 Increased Reimbursement Rates Vaccine Administration		
HIPAA Procedure Code	**Medicaid Fee For Service (FFS) Reimbursement**	**PeachCare for Kids® (PCK) Fee For Service (FFS) Reimbursement**
90473	$23.54	$23.54
90474	$11.98	$18.50

APPENDIX C-2

Vaccine Procedure and Diagnosis Codes

(Ages Birth through 18 years)

The following vaccine procedure and diagnosis codes must be included on the claim, following the vaccine administration code, when billing for vaccine administration.

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
90620	EP	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use (10-18 years) [Bexsero]
90621		Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use (10-18 years) [Trumenba]
90633	EP	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636	EP	Combination Hepatitis A/Hepatitis B vaccine, adult dosage, 3 dose, for intramuscular use (18 years)
90647	EP	Haemophilus influenzae type B vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use
90648		Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use
90651	EP	Human Papillomavirus (HPV) vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58 nonavalent (9vHPV), 2 or 3-dose schedule, for intramuscular use (females and males 9 years and older) [Gardasil 9]
90674	EP	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit preservative and antibiotic free, 0.5mL dosage, for intramuscular use
90685		Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90686		Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687		Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
90688		Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90672		Influenza virus vaccine (FluMist), quadrivalent, live (LAIV4), for intranasal use (2 years and older)
90756		Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use

Rev. 01/08
Rev. 07/08
Rev. 07/10
Rev. 07/11
Rev. 07/12
Rev. 01/13
Rev. 03/13
Rev. 01/14
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 01/15
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 04/16
Rev. 10/16
Rev. 01/17
Rev. 01/18
Rev. 04/18
Rev. 10/18
Rev. 01/19

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
90670	EP	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90680	EP	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use (RotaTeq)
90681	EP	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use (Rotarix)
90696	EP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and inactivated poliovirus vaccine, (DTaP-IPV), for intramuscular use (ages 4-6 years)
90698	EP	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenza type B, and inactivated poliovirus vaccine (DTaP-IPV/Hib), for intramuscular use
90700	EP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for intramuscular use (ages younger than 7 years)
90707	EP	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
90710	EP	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90713	EP	Poliovirus vaccine (IPV), inactivated, for subcutaneous or intramuscular use
90714	EP	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for intramuscular use (7 years to 18 years, 11 months)
90715	EP	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for intramuscular use (7 years to 18 years, 11months)
90716	EP	Varicella virus vaccine (VAR), live, for subcutaneous use
90723	EP	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and inactivated poliovirus vaccine (DTaP-Hep B-IPV), for intramuscular use
90732	EP	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use
90734	EP	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diptheria toxoid carrier, (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use
90744	EP	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90747		Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use

Rev. 01/08
Rev. 07/08
Rev. 07/10
Rev. 07/11
Rev. 07/12
Rev. 01/13
Rev. 03/13
Rev. 01/14
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 01/15
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 04/16
Rev. 10/16
Rev. 01/17
Rev. 01/18
Rev. 04/18
Rev. 07/19

Vaccine Procedure and Diagnosis Codes

(Ages 19 through 20 years)

The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration for vaccines administered to Medicaid-eligible members nineteen (19) years of age through twenty (20) years of age. Providers who administer any one of the vaccines listed below will receive reimbursement for administering each vaccine PLUS reimbursement for the vaccine product. The reimbursement rates for the vaccine products may be found in the Physicians' Injectable Drug List Manual. Providers must include the vaccine's procedure and diagnosis codes on the claim.

Rev. 10/13
Rev. 01/14
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 04/15
Rev. 07/15
Rev. 10/15
Rev. 01/16
Rev. 04/16
Rev. 10/16
Rev. 01/17
Rev. 10/17
Rev. 01/18
Rev. 04/18
Rev. 10/18
Rev. 01/19
Rev. 10/20

Vaccine Procedure and Diagnosis Codes

(Ages 19 through 20 years)

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
90620	EP	Meningococcal recombinant protein and outer member vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use (Bexsero)
90621		Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use (Trumenba)
90632	EP	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use
90636		Combination Hepatitis A/Hepatitis B vaccine, adult dosage, 3 dose, for intramuscular use
90746	EP	Hepatitis B vaccine (HepB), adult dosage 3 dose schedule, for intramuscular use
90747		Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage 4 dose, for intramuscular use
90651	EP	Human Papillomavirus HP vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3-dose schedule, for intramuscular use (females & males) [Gardasil 9]
90674	EP	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5mL dosage, for intramuscular use
90682		Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90686		Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90688		Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90672		Influenza virus vaccine (FluMist), quadrivalent, live (LAIV4), for intranasal use (2 years and older)
90756		Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
90707	EP	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use

Vaccine Procedure and Diagnosis Codes

(Ages 19 through 20 years)

Rev. 10/13
Rev. 01/14
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 04/15
Rev. 07/15
Rev. 10/15
Rev. 01/16
Rev. 04/16
Rev. 10/16
Rev. 01/17
Rev. 10/17
Rev. 01/18
Rev. 04/18
Rev. 10/18
Rev. 01/19
Rev. 07/19

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
90713	EP	Poliovirus vaccine (IPV), inactivated, for adults at high risk, for subcutaneous or intramuscular use
90714	EP	Tetanus and diphtheria toxoids (Td) absorbed, preservative free, for intramuscular use
90715	EP	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for intramuscular use
90716	EP	Varicella virus vaccine (VAR), live, for subcutaneous use
90670	EP	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90732	EP	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use
90734	EP	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diptheria toxoid carrier, (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use

APPENDIX C-3

Tuberculin (TB) Skin Test Procedure Codes

Rev. 03/13
Rev. 04/13
Rev. 04/14
Rev. 07/14
Rev. 04/15
Rev. 10/15

The maximum reimbursement rate for the TB skin test provided by private providers is $8.13 and $3.00 for public health providers.

Use the following procedure and diagnosis codes to document the Tuberculin Skin Test.

HIPAA Procedure Code	ICD-10 Diagnosis Code	HIPAA Modifier	Procedure Code Description	Fee For Service Reimbursement
86580	Z11.1	EP	TB Skin Test	$3.00 (public) $8.13 (private)

APPENDIX C-4

Blood Lead Level Testing Procedure Codes

Blood Lead Level (BLL):

Blood Lead Screenings should be performed at the 12 and 24 month periodic visits (or catch-up visits). There are two tests used to obtain blood lead level (BLL) specimens: capillary blood test or venous blood test. Finger stick capillary blood tests can be done as the initial screening; however, a lab analyzed sample is necessary for confirmation. The specimen may be sent to a private laboratory for analysis, the analysis may be performed using an in-office blood lead level analyzer (the Lead Care II Analyzer uses capillary blood), or sent to the Georgia Public Health Laboratory (GPHL).

Rev. 07/11
Rev. 07/12
Rev. 03/13
Rev. 04/14
Rev. 07/14
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 10/19

Providers should bill code 83655 with the EP modifier, diagnosis code Z13.88 *(or other applicable diagnosis code that indicates the child is receiving a screening blood lead test)*, on the same claim with the appropriate blood test code 36415 (blood lead venous) or 36416 (blood lead capillary).

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description	ICD-10 Diagnosis Code
83655	EP	Blood Lead Level Test	Z13.88*
36415	EP	Blood Lead Level Venous	Z13.88
36416	EP	Blood Lead Level Capillary	Z13.88

**Z13.88 (or other applicable diagnosis code that indicates the child is receiving a screening blood lead test)*

Providers who send BLL specimen to the Georgia Public Health Laboratory (GPHL) will be billed $10.00 lab handling fee assessed by the GPHL. Therefore, Fee For Service (FFS) providers should bill code 83655 with modifiers EP, 90 or EP, 91 and diagnosis code Z13.88 on the same claim with the appropriate codes (36415 or 36416) as seen below. This billing will result in a FFS reimbursement of $10.00 for the lab handling fee assessed by the GPHL. This reimbursement is only available when documentation supports that the BLL specimen was sent to the GPHL.

HIPAA Procedure Code	HIPAA Modifier	ICD-10 Diagnosis Code	Fee For Service Reimbursement
83655	EP, 90 or EP, 91	Z13.88*	$10.00 (only available when documentation supports that the BLL specimen was sent to the GPHL)
36415	EP	Z13.88	
36416	EP	Z13.88	

**Z13.88 (or other applicable diagnosis code that indicates the child is receiving a screening blood lead test)*

Diagnosis Code/ Modifier	Description
Z13.88	Encounter for screening for disorder due to exposure to contaminants.
Modifier 90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting practitioner, the procedure may be identified by adding modifier 90 to the usual procedure number.
Modifier 91	Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.

APPENDIX D

Children's Intervention Services

The Children's Intervention Services (CIS) program offers coverage for restorative and/or rehabilitative services to eligible members in non-institutional settings. Services must be determined medically necessary and be recommended and documented as appropriate interventions by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law, for the maximum reduction of physical disability or developmental delay and restoration of the member to the best possible functional level.

The CIS program is comprised of seven intervention services that must be provided by licensed practitioners of the healing arts. The seven services are:

- Audiology
- Nursing
- Nutrition provided by licensed dieticians
- Occupational Therapy
- Physical Therapy
- Counseling provided by licensed clinical Social Workers
- Speech-language Pathology

Qualified providers must be currently licensed as audiologists, registered nurses, dietitians, occupational therapists, physical therapists, clinical social workers, or speech-language pathologists.

APPENDIX E

Medicaid Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?
If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, you must contact the NET Broker serving the county you live in to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?
Rev. 4/12
The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, call the Member CIC at 866-211-0950.

Region	Broker/Phone Number	Counties Served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White, and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb, and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs, and Wilkinson

Rev. 4/12
Rev. 7/12

Region	Broker/Phone Number	Counties Served
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Truetlen, Ware, Warren, Washington, Wayne, Wheeler, and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox, and Worth

Rev. 4/12
Rev. 7/12

APPENDIX F

Childhood Obesity – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Rev. 10/13
Rev. 07/14
Rev. 07/16

Body Mass Index (BMI)

What is BMI?

Body Mass Index (BMI) is used as a screening tool to identify possible weight problems for children and adolescents. The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend the use of BMI to screen for overweight and obesity in children and adolescents aged 2 through 19 years.

BMI is a number calculated from a child's weight and height. BMI does not measure body fat directly, but it is a reliable indicator of body fatness for most children and adolescents.

For children and adolescents, BMI is age- and sex-specific and is often referred to as BMI-for-age. A child's weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults because children's body composition varies as they age and varies between boys and girls.

What is a BMI percentile?

After the BMI is calculated for children and adolescents, the BMI number is plotted on the BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age. The CDC's growth charts show the weight status categories used with children and adolescents.

WEIGHT STATUS CATEGORY	PERCENTILE RANGE
Underweight	Less than the 5th percentile
Healthy Weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	Equal to or greater than the 95th percentile

These percentiles are based on the CDC's growth charts which **are available at http://www.cdc.gov/growthcharts/**

How to calculate BMI using a handheld calculator?

Rev. 10/13

The BMI can be calculated using either English or metric units.

With the metric system, the formula for BMI is weight in kilograms divided by height in meters squared. Since height is commonly measured in centimeters, an alternate calculation formula, dividing the weight in kilograms by the height in centimeters squared, and then multiplying the result by 10,000, can be used.

Formula: weight (kg) / [height (m)]^2

Rev. 07/14

When using English measurements, ounces (oz.) and fractions must be changed to decimal values. Then, calculate BMI by dividing weight in pounds (lbs.) by height in inches (in) squared and multiplying by a conversion factor of 703. Plot the calculated BMI to obtain the BMI percentile.

Formula: weight (lb.) / [height (in)]^2 x 703

How to interpret BMI?

Calculating the BMI-for-age for children of different ages and sexes may yield the same numeric result, but the result may fall at a different percentile for each child for one or both of the following reasons:

- The normal BMI-related changes that take place as children age and as growth occurs (ex. The amount of body fat changes with age).

- The normal BMI-related differences between sexes (ex. The amount of body fat differs between girls and boys).

Documentation for HEDIS Compliance – Weight Assessment

Documentation in the medical record for BMI must include the following:

- Height
- Weight
- BMI percentile

Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile: BMI percentile documented as a value (e.g., 85th percentile) OR BMI percentile plotted on an age-growth chart. Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets HEDIS criteria.

Rev. 04/14
Rev. 07/14
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 01/18
Rev. 04/18

ICD-10 Codes to Identify BMI

Body Mass Index (BMI) – Pediatrics		
BMI Code	**BMI Percentile**	**Range**
Z68.51	< 5th percentile for age	Underweight
Z68.52	5th to < 85th percentile for age	Normal/ Healthy Weight Range
Z68.53	85th to < 95th percentile for age	Overweight
Z68.54	≥ 95th percentile for age	Obese

FFS EPSDT providers are encouraged to report BMI diagnosis codes with the EPSDT preventive health codes. Do not point the preventive health visit code to the BMI diagnosis code because this will cause the FFS claim to deny payment.

Rev. 10/13
Rev. 01/14
Rev. 10/14
Rev. 07/16

Counseling for Nutrition

Guidelines

The *Dietary Guidelines for Americans (http://health.gov/dietaryguidelines/2015/guidelines/)* comprise core principles to help people, ages 2 years and older, develop healthy lifestyles based on individual needs, likes, and dislikes related to both eating and physical activity. The Dietary Guidelines recommend that children and adolescents consume a healthy eating pattern that accounts for all foods and beverages within an appropriate caloric level. A healthy eating pattern includes a variety of vegetables from all of the subgroups, fruits, grains, fat-free or low-fat dairy, a variety of protein foods and oils. A healthy eating pattern limits saturated fats and *trans* fats, added sugars, and sodium.

Documentation for HEDIS compliance – Counseling for Nutrition

Documentation (in the medical record) of counseling for nutrition must include a statement indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

ICD-10 Code to Identify Counseling for Nutrition

- Z71.3 – nutritional counseling

FFS EPSDT providers are encouraged to report the nutrition diagnosis code with the EPSDT preventive health codes. Do not point the preventive health visit code to the nutrition and physical activity counseling diagnosis code because this will cause the FFS claim to deny payment.

Rev. 10/13
Rev. 01/14
Rev. 10/14
Rev. 07/16

Counseling for Physical Activity

Guidelines

The *Physical Activity Guidelines for Americans (http://health.gov/paguidelines/guidelines/children.aspx)* describe the types and amounts of physical activity that offer substantial health benefits for children and adolescents (ages 6 to 17) and adults. The *Physical Activity Guidelines for Americans* complement the *Dietary Guidelines for Americans*, and together the documents provide guidance on the importance of being physically active and eating healthy foods to promote health and reduce the risk of chronic diseases. The Physical Activity Guidelines recommend that children and adolescents have 60 minutes (1 hour) or more of physical activity each day. Physical activity includes aerobic/endurance activities (to increase cardiorespiratory fitness), muscle-strengthening (resistance training which builds strong muscles), and bone-strengthening (weight-bearing or weight-loading activities which promote bone growth and strength).

Documentation for HEDIS Compliance – Counseling for Physical Activity

Documentation (in the medical record) of counseling for physical activity must include a statement indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

The following notations or examples of documentation are not compliant with HEDIS requirements:

Rev. 10/16
Rev. 01/18

- **BMI**
  - No BMI percentile documented in medical record or plotted on age-growth chart.
  - Notation of BMI value only.
  - Notation of height and weight only.

- **Nutrition**
  - No counseling/education on nutrition and diet.
  - Counseling/education before or after the HEDIS measurement year
  - Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.
  - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.
  - Documentation related to a member's "appetite" does not meet criteria

- **Physical Activity**
  - No counseling/education on physical activity.
  - Notation of "cleared for gym class" along without documentation of a discussion.
  - Counseling/education before or after the HEDIS measurement year.
  - Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.
  - Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.
  - Notation solely related to screen time (computer or television) without specific mention of physical activity.

Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. **Services specific to the assessment or treatment of an acute or chronic condition do not count toward the "Counseling for Nutrition" and "Counseling for Physical Activity" measures.**

APPENDIX G

EPSDT Program Required Equipment Form

- ☐ Scale for Weighing Infants **present**
- ☐ Scale for Weighing Children and Adolescents **present**
- ☐ Measuring Board or Device for measuring Length or Height in the recumbent position for Infants and Children up to the age of two (2) **present**
- ☐ Measuring Board or Device for measuring Height in the vertical position for children who are over two (2) years old **present**
- ☐ Blood Pressure apparatus with infant, child, and adult cuffs **present**
- ☐ Screening audiometer **present**
- ☐ Centrifuge or other device for measuring hematocrit or hemoglobin may be **present**
- ☐ Eye charts appropriate for age of the child **present**
- ☐ Developmental/Behavioral, Alcohol/Substance Abuse and Depression screening tools and supplies **present** (*The required developmental screenings at ages 9 months, 18 months, and 30 months **must** be accomplished using one or more of the recommended standardized developmental screening tools specified in Section 902.2)*

Rev. 07/14
Rev. 10/14
Rev. 07/15
Rev. 01/16

- ☐ Vaccines and immunization administration supplies **present**
- ☐ Lab supplies for appropriate lab tests/screenings **present**
- ☐ Ophthalmoscope and Otoscope **present**

The information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medicaid, for purpose of enrolling in the EPSDT Program. I understand that falsification, omission or misrepresentation of any information in this enrollment document will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment request, and may be punishable by criminal, civil or other administrative actions. I understand that my completion of this form certifies that I have the necessary equipment as listed in Part II-Policies and Procedures Manual for the EPSDT Program.

_____ _____

Provider Name *Date*

_____

Provider Title

_____

Provider/Confirmation Number

APPENDIX H

Georgia Families

Rev. 01/11
Rev. 10/12
Rev. 04/14
Rev. 07/17
Rev. 10/18

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup RealSolutions in Healthcare Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource CareSource 1-855-202-1058 www.caresource.com
peach state health plan Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia, Inc. WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:	
Included Populations	**Excluded Populations**
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.